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**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the First Amended Accusation
Against:

MAHYAR OKHOVAT, M.D.

29525 Canwood Street, Suite 109
Agoura Hills, California 91301

Physician's and Surgeon's Certificate
No. A 85646,

Respondent.

OAH No. 2018120076

Case No. 800-2017-038106

FIRST AMENDED ACCUSATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On January 9, 2004, the Board issued Physician's and Surgeon's Certificate Number A 85646 to Mahyar Okhovat, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, unless

1 renewed.

2 **JURISDICTION**

3 3. This First Amended Accusation is brought before the Board, under the authority of
4 the following laws. All section references are to the Business and Professions Code unless
5 otherwise indicated.

6 4. Section 2227 of the Code provides that a licensee who is found guilty under the
7 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
8 one year, placed on probation and required to pay the costs of probation monitoring, or such other
9 action taken in relation to discipline as the Board deems proper.

10 5. Section 2234 of the Code states, in pertinent part:

11 "The board shall take action against any licensee who is charged with unprofessional
12 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
13 limited to, the following:

14 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
15 violation of, or conspiring to violate any provision of this chapter.

16 "...

17 "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
18 omissions. An initial negligent act or omission followed by a separate and distinct departure from
19 the applicable standard of care shall constitute repeated negligent acts.

20 "(1) An initial negligent diagnosis followed by an act or omission medically appropriate for
21 that negligent diagnosis of the patient shall constitute a single negligent act.

22 "(2) When the standard of care requires a change in the diagnosis, act, or omission that
23 constitutes the negligent act described in paragraph (1), including, but not limited to, a
24 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
25 applicable standard of care, each departure constitutes a separate and distinct breach of the
26 standard of care.

27 "..."

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1 6. Section 2266 of the Code states:
2 “The failure of a physician and surgeon to maintain adequate and accurate records relating
3 to the provision of services to their patients constitutes unprofessional conduct.”

4 **FIRST CAUSE FOR DISCIPLINE**

5 **(Repeated Negligent Acts)**

6 7. Respondent is subject to disciplinary action under Code section 2234, subdivision
7 (c), in that he committed repeated negligent acts in his care and treatment of Patient A.¹ The
8 circumstances are as follows:

9 8. During the relevant time period, Respondent was the primary neurologist and pain
10 specialist at the Pain Management & Injury Relief Medical Center (PMIR) located in Santa
11 Monica and Thousand Oaks, California.

12 9. On October 14, 2008, Patient A, a 37-year-old female, presented to PMIR for pain
13 management of chronic lower back and bilateral lower extremity pain. Nine years prior, Patient
14 A had gastric bypass surgery and four months prior, she had thigh surgery. Patient A also had
15 been diagnosed with chronic anxiety, depression and severe sleep disorders.

16 10. At PMIR, Patient A was treated by Respondent who managed her pain medication
17 and symptoms. Patient A was concurrently being prescribed medications for her anxiety,
18 depression and insomnia by other providers.

19 11. In December 2008, Patient A was hospitalized at Simi Valley Hospital after
20 overdosing on Ambien (a Schedule V sleep medication).

21 12. From the time she first presented to PMIR through March 2009, Respondent acted as
22 Patient A’s pain management specialist. During that time period, he prescribed her both oral and
23 topical pain medication. The medications Respondent prescribed to Patient A included Percocet²

24 ¹ In this First Amended Accusation, the patient is referred to as “Patient A” to protect her
25 right of privacy. The patient’s full name was disclosed to Respondent during the course of Board
26 Investigation No. 800-2017-038106 and will be disclosed to Respondent again when discovery is
27 provided pursuant to Government Code section 11507.6.

28 ² Percocet is the brand name for oxycodone with acetaminophen, a Schedule II opiate
narcotic.

1 (10/325) and Lyrica.³

2 13. Respondent did not see Patient A between March 2009 through November 2009, at
3 which point she was referred back to Respondent. During this time period, another treating
4 physician had prescribed her Fentanyl⁴ 50 mcg/hr patch and Norco⁵ 10/325. Patient A had also
5 reportedly had a reversal of her gastric bypass.

6 14. Between November 2009 and October 2011, Respondent managed Patient A's pain
7 medication and symptoms.

8 15. In February 2011, Patient A had lost a significant amount of weight and her pain was
9 stable on her current medication regime. Respondent's plan was to wean her off of Fentanyl.
10 Respondent started her on Savella (a selective serotonin and norepinephrine reuptake inhibitor
11 (SNRI)) for her fibromyalgia and depression.

12 16. In May 2011, Patient A reported severe pain in her lower extremities. Respondent
13 restarted her on Fentanyl 25 mcg/hr.

14 17. In July 2011, Patient A reported abdominal symptoms, including nausea and
15 vomiting. Respondent referred Patient A to her bariatric surgeon. Respondent also refilled her
16 Fentanyl and Norco prescriptions, among others.

17 18. In September 2011, Patient A planned to have another gastric surgery. Respondent
18 recommended discontinuing Fentanyl prior to her surgery and because she was experiencing
19 nausea and vomiting.

20 19. In October 2011, Patient A's gastric surgery was reportedly postponed. Respondent
21 restarted her on Fentanyl.

22 20. In November 2011, Respondent again planned to decrease her Fentanyl dosage prior
23 to her gastric surgery.

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25 ³ Lyrica, a Schedule V medication, is used to treat chronic pain, such as that associated
26 with fibromyalgia.

27 ⁴ Fentanyl is a Schedule II opiate narcotic, typically prescribed in patch form.

28 ⁵ Norco is a brand name for hydrocodone and acetaminophen, a Schedule II opiate
narcotic.

1 21. In December 2011, Patient A was post abdominal surgery. While her abdominal pain
2 had improved, she continued to complain of severe bilateral lower extremity pain and new onset
3 neck pain that was myofascial. Respondent gave Patient A trigger point injections in the office,
4 increased her Fentanyl dosage and refilled her prescriptions.

5 22. Respondent's last visit with Patient A was on December 10, 2012.

6 23. Patient A died on June 2, 2013.

7 24. During the relevant time period, the applicable standard of care in the medical
8 community required that a medical history and physical examination be conducted of a patient
9 that includes an assessment of the pain; physical and psychological function; a substance abuse
10 history; history of prior pain treatment; an assessment of underlying or coexisting diseases or
11 conditions; and documentation of the presence of a recognized medical indication for the use of a
12 controlled substance.

13 25. During the relevant time period, the applicable standard of care in the medical
14 community required that a treatment plan, informed consent, periodic review and consultations be
15 reflected in a patient's medical record.

16 26. During the course of Respondent's care and treatment of Patient A, information
17 pertaining to Patient A's treatment plans and objectives and evidence of informed consent,
18 periodic review and consultations are either frequently, or entirely, missing from her medical
19 record. These deficiencies in Patient A's medical record on the part of Respondent constitute
20 simple departures from the standard of care.

21 27. The applicable standard of care in the medical community requires that a medical
22 provider's notes in a patient's medical record be legible.

23 28. Respondent's handwritten medical notes detailing Patient A's examinations are
24 consistently illegible. This constitutes a simple departure from the standard of care.

25 29. During the relevant time period, the applicable standard of care in the medical
26 community required that when a patient is suspected of having made a suicide attempt that
27 evidence of appropriate medication use is required. Urine testing is the standard method.

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30. During the course of Respondent's care and treatment of Patient A, there is no evidence that Patient A was ever drug tested, including but not limited to through urine analysis, even though she had overdosed on Ambien in December 2008. Respondent's failure to drug test Patient A to ensure that she was taking her medications as prescribed and not abusing other substances is a simple departure from the standard of care.

31. Respondent's acts and/or omissions as set forth in paragraphs 9 through 30, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts in violation of section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

32. Respondent is subject to disciplinary action under Code sections 2234, subdivision (a), and 2266, in that he failed to maintain adequate and accurate records for Patient A. The circumstances are as follows:

33. Paragraphs 8 through 30 are incorporated by reference and re-alleged as if fully set forth herein.

34. Respondent's acts and/or omissions as set forth in paragraphs 8 through 29 and 32, above, whether proven individually, jointly, or in any combination thereof, constitute the failure to maintain adequate and accurate records pursuant to section 2266 of the Code. As such, cause for discipline exists.

PRAAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:


1. Revoking or suspending Physician's and Surgeon's Certificate Number A 85646, issued to Mahyar Okhovat, M.D.;
2. Revoking, suspending or denying approval of Mahyar Okhovat, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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1 3. If placed on probation, ordering Mahyar Okhovat, M.D. to pay the Board the costs of
2 probation monitoring; and

3 4. Taking such other and further action as deemed necessary and proper.

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5 DATED: July 26, 2019


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant